

MONTANA LEGISLATIVE HISTORY

Chapter 522 19 55

Bill H 446 S \_\_\_\_\_ Original bill & history C

H. Committee on Health Care Select

Hearing Date(s) Feb 05 ✓ C

Feb 16 ✓ C

\_\_\_\_\_ C

\_\_\_\_\_ C

Date Out Feb 12 ✓ C

S. Committee on Joint Health Care Select

Hearing Date(s) Mar 05 ✓ C

Mar 16 ✓ C

\_\_\_\_\_ C

\_\_\_\_\_ C

Mar 17 ✓ C

Did this bill originate in an interim committee? Yes No

Committee \_\_\_\_\_

Report \_\_\_\_\_

Free Conference Apr 06 ✓ C

## CONCURRED

91 8

## SENATE

4/12 2ND READING GOVERNOR'S AMENDMENTS

## CONCURRED

49 0

4/13 3RD READING GOVERNOR'S AMENDMENTS

## CONCURRED

50 0

4/14 SIGNED BY SPEAKER

4/18 SIGNED BY PRESIDENT

4/18 TRANSMITTED TO GOVERNOR

4/25 SIGNED BY GOVERNOR

## CHAPTER NUMBER 521

EFFECTIVE DATE: 04/25/95—SECTIONS 1-5, 9 &amp; 18-20

EFFECTIVE DATE: 01/01/96—SECTIONS 6-8 &amp; 10-17

HB 446 INTRODUCED BY ORR, ET AL.

PROHIBIT EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM  
HEALTH BENEFIT PLANS

2/06 INTRODUCED

2/06 FIRST READING

2/06 REFERRED TO HEALTH CARE SELECT

2/09 HEARING

2/17 COMMITTEE REPORT—BILL PASSED AS AMENDED

2/20 2ND READING PASSED AS AMENDED

95 4

2/22 3RD READING PASSED

94 5

## TRANSMITTED TO SENATE

2/27 FIRST READING

2/27 REFERRED TO BUSINESS &amp; INDUSTRY

3/06 REREFERRED TO JOINT HEALTH CARE SELECT

3/09 HEARING

3/18 COMMITTEE REPORT—BILL CONCURRED AS AMENDED

3/21 FISCAL NOTE REQUESTED

3/21 2ND READING CONCURRED

50 0

3/22 3RD READING CONCURRED

49 0

## RETURNED TO HOUSE WITH AMENDMENTS

3/23 FISCAL NOTE RECEIVED

3/24 FISCAL NOTE PRINTED

3/31 2ND READING AMENDMENTS NOT CONCURRED

81 16

3/31 FREE CONFERENCE COMMITTEE APPOINTED

4/05 HEARING

4/06 FREE CONFERENCE COMMITTEE REPORT NO. 1

4/08 2ND READING FREE CONFERENCE COMMITTEE

REPORT NO. 1 ADOPTED

98 0

4/10 3RD READING FREE CONFERENCE COMMITTEE

REPORT NO. 1 ADOPTED

98 0

## SENATE

4/04 FREE CONFERENCE COMMITTEE APPOINTED

4/08 FREE CONFERENCE COMMITTEE REPORT NO. 1

4/10 2ND READING FREE CONFERENCE COMMITTEE

REPORT NO. 1 ADOPTED

49 0

4/11 3RD READING FREE CONFERENCE COMMITTEE

REPORT NO. 1 ADOPTED

47 0

4/13 SIGNED BY SPEAKER

4/18 SIGNED BY PRESIDENT

4/18 TRANSMITTED TO GOVERNOR

4/21 SIGNED BY GOVERNOR

## CHAPTER NUMBER 522

EFFECTIVE DATE: 04/21/95

MINUTES

MONTANA HOUSE OF REPRESENTATIVES  
54th LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By VICE CHAIRMAN CARLEY TUSS, on February 9,  
1995, at 3:05 p.m.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)  
Rep. Carley Tuss, Vice Chairman (D)  
Rep. Beverly Barnhart (D)  
Rep. John Johnson (D)  
Rep. Royal C. Johnson (R)  
Rep. Betty Lou Kasten (R)  
Rep. Thomas E. Nelson (R)  
Rep. Bruce T. Simon (R)  
Rep. Richard D. Simpkins (R)  
Rep. Liz Smith (R)

Members Excused:

Rep. Carolyn M. Squires (D)

Members Absent: None

Staff Present: David Niss, Legislative Council  
Susan Fox, Legislative Council  
Vivian Reeves, Committee Secretary

Please Note: These are summary minutes. Testimony and  
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 446  
Executive Action: None

{Tape: 1; Side: A}

HEARING ON 446

Opening Statement by Sponsor:

REP. SCOTT ORR, House District 82, Libby, Montana, stated that  
HB 446 deals with the preexisting conditions of insurance reform.  
There have been extensive and excruciating conversations with  
insurance groups in the formulation of HB 446. He stated that a  
proponent would provide amendments to the bill which would make a  
good bill better.

Proponents' Testimony:

Tanya Ask, representing Blue Cross/Blue Shield of Montana (BCBS), stated that HB 446 "applies a uniform preexisting waiting period across the board with our amendments," to individual and group contracts. Currently, state law allows insurance companies who write group or individual business in Montana to look back a period of five years to see whether an individual who is receiving treatment for something and has just come on board to a contract has previously received treatment for that. Ms. Ask remarked insurance that is supposed to be an indemnification or a benefit for unforeseen risk. An individual should not buy insurance knowing they have a problem; they should buy insurance before they have a problem. Ms. Ask stated that if somebody receives a knee injury today and buys insurance tomorrow, their knee injury will not be covered for a period of one year. This particular law would continue that preexisting waiting period for one year. Under current law, insurance companies can look back five years. Did that knee injury occur three, four, or five years ago? Ms. Ask stated that HB 446 would modify the amount of time that insurance companies could look back from five years to three years. This shortening of the period of time that insurance companies may look back for preexisting conditions provides consumer protection.

Ms. Ask reviewed the amendments and presented them to the Committee. EXHIBIT 1 She stated that HB 446 is a good bill which allows more people to receive benefits over a shorter period of time because insurance companies would look back only three years instead of five years. She indicated that other questions have surfaced with respect to HB 446 by the insurance department and additional clarifications may be necessary in addition to the submitted amendments.

Susan Good, representing Heal Montana, stated the purpose of HB 446 was to define preexisting language in Montana statutes. She stated that the function of preexisting conditions is to set the amount of time that an insurance company can look back to gather information on the health history of the proposed insured. She indicated that HB 446 does not prevent insurance companies from putting exclusionary riders on policies. She clarified that a rider is a provision that states an insurance company may choose to not cover a specific ailment for either a certain period of time, or in some cases it's been indefinitely; however, the individual's other health care expenses would be covered. She indicated that exclusionary riders in HB 446 would be exclusionary for four years; after that they would be covered. She stated HB 446 is consumer-friendly and allows insurance companies to function as they are designed.

Tom Hopgood, representing the Health Insurance Association of America, spoke in support of HB 446. He stated that he would endorse the amendments presented by Ms. Ask.

Larry Akey, representing the Montana Association of Life Underwriters, and the Independent Insurance Agents of Montana, spoke in support of HB 446.

Ed Grogan, representing the Montana Medical Benefit Plan (MMBP), stated that riders aren't just a benefit to the insurance company; but often are a large benefit to the insured. It allows an individual affordable coverage for health care, excluding the rider. Mr. Grogan strongly urged the Committee to differentiate between a preexisting condition and a preexisting riderable condition, as in 1994 the Insurance Commissioner's office determined that they are one and the same. The Commissioner's office stipulated that the Montana Medical Plan remove all riders at the end of 12 months from their insurance policies. "The problem in doing that, is that we have a lot of people that are riders for some very catastrophic conditions." He indicated that when the riders are removed, in many cases, MMBP has to rate people up 250%.

He stated that, "we think it's terrible to have to rate those people up like that, and we feel very badly." He urged the Committee to follow BCBS's recommendation of an amendment to allow riders. He indicated that MMBP had some concern about the 48 months, because "48 months from now we could still be in a catastrophic condition and have to give those people a huge rate." He recommended "that if an individual, at any time in the future, can give us medical evidence that this condition no longer exists or is no longer a catastrophic condition, that a petition to our underwriting people may be made to remove that rider. ... We would like to look at the possibility of removing the 48-month limit and make it a lifetime."

Dean Randash, NAPA Auto Parts, Helena, Montana, supported the concept of HB 446, but inquired why the rider should have a four year limit, whereas the small employer group has only a 12-month limit. He suggested that in fairness that these be made equal.

Opponents' Testimony: None.

Informational Testimony:

Claudia Clifford, Department of Insurance, discussed technical concerns about HB 446. EXHIBIT 2

Questions From Committee Members and Responses:

REP. TOM NELSON inquired if this will cover all enforced policies.

Ms. Ask stated that usually modified laws applied to contracts issued from that point forward or from the effective date of the law.

REP. NELSON inquired if putting a 48-month limit on "elimination riders" would encourage companies to leave all elimination riders on for at least 48 months.

{Tape: 1; Side: B}

Ms. Ask stated that in the past, exclusionary riders were not limited and could last for the life of the policy. She indicated that a company would not be excluding a particular condition forever, but would only be excluding it for up to 48 months. She stated that putting a 48-month limit on exclusionary riders would allow more people to be covered than if it had a 24-month limit.

REP. NELSON indicated that it would be inflationary if the riders are limited.

Ms. Ask stated that is correct. If a company is not allowed a rider a condition forever, eventually claims would be heard as a result of that medical condition which would make the policy more expensive than it may otherwise have been.

REP. RICHARD SIMPKINS inquired about rider diabetes which can lead to a variety of other medical complications.

Ms. Ask stated that it would depend on the individual companies underwriting that particular condition.

REP. SIMPKINS inquired if pregnancy could be written in so that it would not be covered until the policy has been in effect for ten months.

Ms. Ask stated that was the purpose for including pregnancy. She stated that medical policies do not always cover disease only. She stated that bone injuries are not necessarily a disease, and pregnancy is a condition treated by medical care. She stated that the reason that pregnancy was included is to clarify that an individual cannot discover that they are pregnant, purchase an insurance policy after the fact and expect that insurance policy to cover it.

REP. SIMPKINS inquired if the pregnancy condition could be worded differently.

Ms. Ask said, "That was our best effort at addressing the situation. There may be other language which would also address it." She stated that a pregnancy may be subject to the 12-month waiting period.

REP. SIMPKINS stated that it is not included in HB 446.

Ms. Ask said she believed that the contained language does include that, however, if it is not clear they are open to suggestions.

REP. SIMPKINS inquired what proposal the Insurance Commission office may offer to cover pregnancy.

Carol Roy, Insurance Commissioner office, stated their effort to go by the Montana Supreme Court rule on maternity be treated as any other illness.

REP. SIMPKINS stated that if pregnancy is treated as an illness, it would fall under the preexisting clause. Ms. Roy answered yes.

REP. SIMPKINS concluded that therefore it would not be covered for 12 months.

Ms. Roy stated if there is medical advisor treatment, currently it would have to be carefully looked at.

REP. SIMPKINS indicated that there is no way to give a time period for pregnancy.

Ms. Roy stated that pregnancy is very difficult to cover on an equitable situation. It is not intended that insurance companies should cover preexisting pregnancies. However, a woman may not know that she is pregnant for a few weeks and those people should be covered. She said just because a condition exists, it doesn't mean that the individual knows that.

REP. SIMPKINS inquired if there is a determined period of time which is acceptable that a woman should know of a pregnancy.

REP. NELSON stated that the attending physician would determine when a pregnancy occurred.

VICE CHAIRMAN TUSS indicated that some of this should be discussed in executive action and to limit this to questions.

REP. SIMPKINS stated that the way this would read is that a woman who is six months pregnant and sought no medical attention, would be covered under this policy.

REP. NELSON said, "Not necessarily."

Ms. Roy stated that maternity is currently treated as any other illness on the policy unless there is medical documentation. The current preexisting condition law does put the company in the position to cover a pregnancy which an individual knows about. However, the application form asks "Are you pregnant, or is anyone to be covered pregnant?" If a woman answers no to that question when, in fact, she knows she is pregnant, then the policy itself will be questioned, and may be rescinded because it's a material misrepresentation on the application.

REP. BEVERLY BARNHART inquired about the people Mr. Randash represents, ie., his 14 employees and the 25,000 other individuals.

Mr. Randash stated that the 25,000 have communicated to him, but he had not spoken to all of them.

REP. BARNHART inquired if it was an organization.

Mr. Randash stated that they are not a formal association, but a part of his business.

REP. BARNHART inquired if Mr. Randash was a paid lobbyist.

Mr. Randash replied, "As far as wages from my business, yes."

REP. BARNHART inquired if he was registered as a paid lobbyist.

Mr. Randash stated that he is registered as a paid lobbyist.

REP. BARNHART restated, "You registered as a paid lobbyist, like a citizen's lobbyist."

Mr. Randash stated that NAPA Auto Parts is the principal agent and that he is the registered lobbyist for NAPA Auto Parts. He inquired if REP. BARNHART would like to see his license.

REP. BARNHART assured him that she believed him and explained that she was just trying to determine who he represented. She inquired if NAPA Auto Parts was a business in Helena, Montana.

Mr. Randash indicated that was correct.

REP. LIZ SMITH inquired about the current preexisting conditions law.

Ms. Ask stated that in the current law there is a provision allowing insurance companies to exclude a preexisting condition for 12 months on both group and individual contracts. The company may look back a period of five years to determine if a condition is preexisting.

REP. L. SMITH inquired why it's necessary to insert the rider amendment into this bill if it's already in current law.

Ms. Ask explained that the rider definition was included because for a number of years exclusionary riders have been an industry practice for individual policies. She indicated that there have been changes over the last couple of sessions regarding the preexisting law. This was done for clarification. It was requested, however, that the exclusionary riders be limited to four years.

REP. L. SMITH indicated that the amendment states that an individual policy of disability insurance may exclude coverage for specific conditions through use of one or more elimination riders. She inquired if disability is not the same as health.

Ms. Ask stated that Montana insurance law defines health and accident insurance with the word "disability."

Closing by Sponsor:

REP. ORR stated that the amendments will be worked on before executive action.

# HOUSE OF REPRESENTATIVES

## Select Committee on Health Care

ROLL CALL

DATE Feb. 9, 1995

| NAME                            | PRESENT | ABSENT | EXCUSED |
|---------------------------------|---------|--------|---------|
| Rep. Scott Orr, Chairman        | ✓       |        |         |
| Rep. Carley Tuss, Vice Chairman | ✓       |        |         |
| Rep. Beverly Barnhart           | ✓       |        |         |
| Rep. John Johnson               | ✓       |        |         |
| Rep. Royal Johnson              | ✓       |        |         |
| Rep. Betty Lou Kasten           | ✓       |        |         |
| Rep. Tom Nelson                 | ✓       |        |         |
| Rep. Bruce Simon                | ✓       |        |         |
| Rep. Dick Simpkins              | ✓       |        |         |
| Rep. Liz Smith                  | ✓       |        |         |
| Rep. Carolyn Squires            |         |        | ✓       |

Amendments  
House Bill 446  
Submitted by Blue Cross and Blue Shield of Montana  
February 9, 1995

Page 1

Line 5

Following: "FROM"  
Strike: "INDIVIDUAL"

Line 11

Following: "otherwise,"  
Strike: "individual"

Lines 12 and 13

Following: "contract of insurance provided by a"  
Strike: "prepaid hospital or medical service plan"  
Insert: "health service corporation or"

Line 13

Following: "contract"  
Strike: the remainder of the sentence

Line 23

Following: "Preexisting Conditions."  
Insert: "(1)"  
Strike: "An individual"  
Insert: "A"

Line 25

Following: "coverage."  
Strike: "An individual"  
Insert: "A"

Line 27

Strike: "(1)"  
Insert: "(a)"

Line 28

Following: "during the"  
Strike: "24"  
Insert: "36"

Line 29

Strike: "(2)"  
Insert: "(b)"

Line 30

Following: "during the"  
Strike: "24"  
Insert: "36"

Page 2

Line 1

Strike: "(3)"  
Insert: "(c)"

Line 2

Insert: "(2) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards."

**New Section 3. Riders.**

An individual policy of disability insurance may exclude coverage for specific conditions through the use of one or more elimination riders. A condition which is excluded by an elimination rider may only be excluded for a period not to exceed 48 months.

Renumber subsequent sections.

STATE AUDITOR  
STATE OF MONTANA

EXHIBIT 2  
DATE Feb. 9, 1995  
HB 446



Mark O'Keefe  
STATE AUDITOR

COMMISSIONER OF INSURANCE  
COMMISSIONER OF SECURITIES

Mr. Chairman, Members of the Committee:

The Department of Insurance has the following technical concerns about HB 446:

Section 1.

Definitions for individual and group coverage already exist in law, therefore this new definition may not be needed. Our Department would prefer to use the definitions currently in code, rather than add a new definition which apply to pre-existing condition limitations.

The definition contains (in lines 15 through 21) exclusions for some types of coverage which is somewhat contrary to the intent of this bill.

For example, an individual buying a specified disease policy for cancer would not have the protection of this pre-ex law; and therefore, the policy could impose an unlimited waiting period or rider for a pre-existing cancer condition incurred anytime in one's past. Or if a person had injured a knee 10 years prior to purchasing an accident only policy, the company would not have to cover the knee in a future accident.

By excluding group conversion plans, individuals who become too sick to work and must convert from their group plan to an individual policy will have a new pre-existing condition waiting period. This is in conflict with 33-22-509, 33-30-1008, 33-31-301(3)(v)(h).

Medicare supplement and long term care insurance have their own specific requirements which relate to pre-existing conditions. If these two types of coverage are to be listed in this law, then 33-22-904 will need to be amended as well. This specific code was changed to comply with federal regulations and will no longer comply if altered to this extent. ~~We anticipate a maximum of six months to get Federal approval for this change.~~ Section 33-22-1108 will also need to be amended.

The Department of Insurance recommends deleting section 1, as adequate definitions exist in code already.

## Section 2.

Section 5 repeals 33-22-110, the current pre-ex law which effects both individual and group insurance. Section 2 creates a new law addressing treatment of pre-existing conditions in individual policies only. Although, section 6 codifies the bill to apply to both individual and group insurance, there is not a section in the bill for how pre-existing conditions should be treated in group insurance. If the intent is to have this bill apply to both individual and group policies, it could be done in section 2.

We also propose the standard language used in current law for referring to individual and group health insurance policies in the attached mock amended bill:

Line 27, sub-section (1) opens the door for numerous questions which often delay the processing of claims. Who would define the term "ordinarily prudent person?" If this provision is retained, then Department needs rulemaking authority for implementation. We suggest deleting sub-section (1). Sub-section (2) is an easier provision to enforce.

We would like to point out that sub-section (3) is in conflict with the Montana Supreme Court ruling in the Banker's Life Case. It would treat pregnancy differently from other medical conditions. Pregnancy could be considered a pre-existing condition even if a woman didn't know she was pregnant. For all other medical conditions, a person would have known about the problem, sought treatment or should have sought treatment as in sub-section (1). We suggest pregnancy situations abide by sub-section (2).

Our last recommendation concerns modifications to 33-22-18<sup>part</sup>. We prefer to use terms consistent with the specific section of code. We have inserted the language previously used in this amendment. In this way, small employer carriers will be clear about the pre-existing condition limitations which apply to small group insurance.

INTRODUCED BY ORR John Wilson Carlisle Josh Lipner  
Denny McKee Deen Barnett L. Smith John

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM INDIVIDUAL HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING SECTIONS 33-22-101 AND 33-22-1811, MCA; AND REPEALING SECTION 33-22-110, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

~~NEW SECTION. Section 1. Definition. (1) As used in (section 2), unless the context indicates otherwise, "individual health benefit plan" means a hospital or medical expense incurred policy or certificate, a subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan, a health maintenance organization subscriber contract issued or delivered for issue to an individual, or a discretionary group trust policy providing hospital or medical expense incurred coverage to individuals.~~

~~(2) The term does not include:~~

~~(a) a self-insured group health plan, a self-insured, multi-employer group health plan, a group conversion plan, or an insured group health plan;~~

~~(b) accident-only, specified-disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; or~~

~~(c) coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance;~~

~~NEW SECTION. Section 2. 1 Preexisting conditions. An individual~~ <sup>ad group?</sup> ~~disability~~  
~~policy, subscriber contract, or certificate of insurance issued or~~  
~~issued for delivery in Montana, or contract which provides coverage~~  
~~to a resident of this state,~~  
~~health benefit plan may, because~~  
~~of a preexisting condition, not deny, exclude, or limit benefits for a covered individual for losses incurred~~  
~~more than 12 months following the effective date of the individual's coverage. An individual health benefit~~  
~~plan may not define a preexisting condition. may not be defined more restrictively than:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice,~~  
~~diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;~~  
~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended by, or~~  
~~received from a provider of healthcare services~~  
~~during the 24 months immediately preceding the effective date of coverage;~~



1 ~~(3) a pregnancy existing on the effective date of coverage.~~

2  
3 Section 3. Section 33-22-101, MCA, is amended to read:

4 "33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, ~~33-22-110~~ <sup>St</sup>  
5 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not  
6 apply to or affect:

7 (1) any policy of liability or workers' compensation insurance with or without supplementary  
8 expense coverage;

9 (2) any group or blanket policy;

10 (3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only  
11 those provisions relating to disability insurance as:

12 (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or  
13 accidental means; or

14 (b) operate to safeguard contracts against lapse or to give a special surrender value or special  
15 benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled,  
16 as defined by the contract or supplemental contract; or

17 (4) reinsurance."  
18

19 Section 4. Section 33-22-1811, MCA, is amended to read:

20 "33-22-1811. Availability of coverage -- required plans. (1) (a) As a condition of transacting  
21 business in this state with small employers, each small employer carrier shall offer to small employers at  
22 least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a  
23 standard health benefit plan.

24 (b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit  
25 plan to any eligible small employer that applies for either plan and agrees to make the required premium  
26 payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this  
27 part.

28 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant  
29 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one  
30 basic health benefit plan and at least one standard health benefit plan in each established class of business.

1 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer  
2 into a class of business, provided that:

3 (A) the criteria are not intended to discourage or prevent acceptance of small employers applying  
4 for a basic or standard health benefit plan;

5 (B) the criteria are not related to the health status or claims experience of the small employers'  
6 employees;

7 (C) the criteria are applied consistently to all small employers that apply for coverage in that class  
8 of business; and

9 (D) the small employer carrier provides for the acceptance of all eligible small employers into one  
10 or more classes of business.

11 (iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the  
12 small employer carrier is no longer enrolling new small businesses.

13 (c) The provisions of this section are effective 180 days after the commissioner's approval of the  
14 basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided  
15 that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this  
16 section are effective on the date that the program begins operation.

17 (2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and  
18 the standard health benefit plans to be used by the small employer carrier.

19 (b) The commissioner may at any time, after providing notice and an opportunity for a hearing to  
20 the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard  
21 health benefit plan on the grounds that the plan does not meet the requirements of this part.

22 (3) Health benefit plans covering small employers must comply with the following provisions:

23 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit  
24 benefits for a covered individual for losses incurred more than 12 months following the effective date of  
25 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively  
26 than

a condition for which medical advice,  
diagnosis, or treatment was recommended by or received from a  
provider of health care services during the 24 months immediately  
preceding the effective date of coverage as in section 1.

~~23-22-110, except that the condition may be excluded for a maximum of 12 months [section 2].~~

27 (b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion  
28 or limitation period with respect to particular services for the period of time an individual was previously  
29 covered by qualifying previous coverage that provided benefits with respect to those services if the  
30 qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an

1 application for new coverage. This subsection (3)(b) does not preclude application of any waiting period  
2 applicable to all new enrollees under the health benefit plan.

3 (c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month  
4 preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting  
5 condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from  
6 the date the individual enrolls for coverage under the health benefit plan.

7 (d) (i) Requirements used by a small employer carrier in determining whether to provide coverage  
8 to a small employer, including requirements for minimum participation of eligible employees and minimum  
9 employer contributions, must be applied uniformly among all small employers that have the same number  
10 of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

11 (ii) A small employer carrier may vary the application of minimum participation requirements and  
12 minimum employer contribution requirements only by the size of the small employer group.

13 (e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier  
14 shall offer coverage to all of the eligible employees of a small employer and their dependents. A small  
15 employer carrier may not offer coverage only to certain individuals in a small employer group or only to part  
16 of the group, except in the case of late enrollees as provided in subsection (3)(c).

17 (ii) A small employer carrier may not modify a basic or standard health benefit plan with respect  
18 to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to  
19 restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health  
20 benefit plan.

21 (4) (a) A small employer carrier may not be required to offer coverage or accept applications  
22 pursuant to subsection (1) in the case of the following:

23 (i) to a small employer when the small employer is not physically located in the carrier's established  
24 geographic service area;

25 (ii) to an employee when the employee does not work or reside within the carrier's established  
26 geographic service area; or

27 (iii) within an area where the small employer carrier reasonably anticipates and demonstrates to  
28 the satisfaction of the commissioner that it will not have the capacity within its established geographic  
29 service area to deliver service adequately to the members of a group because of its obligations to existing  
30 group policyholders and enrollees.

1 (b) A small employer carrier may not be required to provide coverage to small employers pursuant  
2 to subsection (1) for any period of time for which the commissioner determines that requiring the  
3 acceptance of small employers in accordance with the provisions of subsection (1) would place the small  
4 employer carrier in a financially impaired condition."

5  
6 NEW SECTION. Section 5. Repealer. Section 33-22-110, MCA, is repealed.

7  
8 NEW SECTION. Section 6. Codification instruction. [Sections 1 and 2] are intended to be codified  
9 as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1.  
10 and 2].

11 -END-

## HOUSE OF REPRESENTATIVES

## VISITOR'S REGISTER

Sel. Comm. Health Care COMMITTEE

BILL NO. HB 446

DATE 2/9/95 SPONSOR(S) Rep. Orr

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

| NAME AND ADDRESS | REPRESENTING                                 | BILL      | OPPOSE | SUPPORT |
|------------------|----------------------------------------------|-----------|--------|---------|
| Tanya Ask        | Blue Cross Blue Shield                       | 446       |        | ✓       |
| Susan Cook       | Heart MT                                     | 446       |        | ✓       |
| LARRY AKEY       | MT ASSOC OF LIFE<br>UNDERWRITERS             | 446       |        | ✓       |
| "                | INDEPENDENT INSURANCE<br>AGENTS OF MONTANA   | 446       |        | ✓       |
| Tom Hopgood      | Health Insurance Assoc-<br>iation of America | HB<br>446 |        | ✓       |
|                  |                                              |           |        |         |
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PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS  
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.



figure is to be cut, a more moderate number such as 750 or 800 would be better.

**Motion:** REP. SMITH MOVED A SUBSTITUTE AMENDMENT TO STRIKE 1000 AND INSERT 750.

REP. SIMON indicated he would oppose this motion on grounds that he would rather err on the side of having the purchasing pools large enough to be viable. He said that the number could be lowered in two years if people are having difficulty putting together the pools.

REP. SIMPKINS stated concern about putting together 1000. Perhaps, once 1000 employees are reached, the figure may drop down but would be required to bring the figure up to a 1000 employees within a year.

*{Tape: 3; Side: 1.}*

**Vote:** Question was called. Roll call vote was taken. The motion failed 8 to 3 with REPS. ROYAL JOHNSON, TOM NELSON AND REP. LIZ SMITH voting yes.

**Vote:** Question was called. Voice vote was taken. Motion carried unanimously.

#### **EXECUTIVE ACTION ON HB 446**

The chair was passed to VICE CHAIRMAN TUSS so that REP. ORR may present his bill for executive action.

**Motion:** REP. ORR MOVED THAT HB 446 DO PASS.

**Motion:** REP. ORR MOVED TO ADOPT THE TECHNICAL AMENDMENT. REP. ORR requested Mr. Akey to explain the amendment.

#### **Discussion:**

Mr. Akey explained the amendment. EXHIBIT 8 He explained that the Commissioner's concern was that there not be two different sets of preexisting condition exclusions in statute. He stated that the Commissioner had some concern about the clause "a condition that would have caused an ordinarily prudent person to seek medical advice," and questioned what an ordinarily prudent person might be. He explained amendment 3, new Section 2 on riders and stated the necessity to exclude disability income policies from the exclusion so that a person with a chronic condition cannot buy a disability income policy, works for five years and then tries to collect under the disability income policy. He clarified that if the chronic condition existed when the disability income policy was purchased, they ought not to be able to just live with it for another five years and then collect on their insurance policy for the rest of their life. He stated

that amendment 5, new section 5 makes HB 446 effective in its entirety upon its passage and approval.

REP. SQUIRES asked what constitutes a prudent person.

Mr. Akey stated that "ordinarily prudent" language was in the statutes until four years ago and "ordinarily prudent" is in the statutes of a number of other states. He said that there are a lot of phrases in code that may not have a precise definition, but when people read it they know what it means. He said that "ordinarily prudent" is one of those. He asked what is a reasonable person and indicated that "reasonable person" is used throughout the statute all the time.

Mr. Hopgood stated that words like "ordinarily prudent," "conspicuously," "reasonable person," "knew or should have known" run all throughout the code book.

REP. SQUIRES referred to the technical amendment, page 1, amendment 3, subsection (b) and asked if it could be re-worded. She asked if "reasonable" would be better language?

Mr. Hopgood asked what the difference was between reasonable and ordinarily prudent.

REP. SQUIRES inquired if "non-negligent person" would be better language?

Mr. Hopgood said that one of the legal elements for negligence is the duty of care that a reasonable person has.

REP. SQUIRES stated her concern that a person may be excluded in the process.

REP. NELSON said that he understood REP. SQUIRES' concern and stated that they're not dealing with social welfare, they're dealing with insurance. He stated a necessity to be very careful when making changes. He stated that the language "ordinarily prudent" or "reasonably prudent" is fine. He commented that if this "gate-keeper" language is taken out, the whole concept of insurance would collapse because it opens the door for people who wait until they are sick with a catastrophic condition before buying insurance. The purpose of insurance is the pooling of people to share in risks. He referred to Ms. Bennett's comment that "5% of the people use 85% of the benefits, and it's those 5% that will get in and destroy it for the rest of us." He stated that he would resist changing it.

REP. SIMON stated that in most cases the evidence with regard to "ordinarily prudent" will be very clear. However, there will be some cases where there is an argument as to whether a person was acting as an ordinarily prudent person. He stated that in some cases it would be decided by the courts.

REP. KASTEN asked if case law backs up the phrase "ordinary prudent" person.

Mr. Niss stated that the courts only construe what is written; they are not the legislators. He stated that there is some case law to construe "ordinarily prudent." He commented that it is a common phrase and in the context of HB 446 is that it means a non-negligent person with respect to his or her own health care.

REP. BARNHART stated some concern about amendment 3, subsection (b). She said that pregnancy should not be on the effective date of coverage because it seems punitive.

REP. NELSON stated that if that is not in there, then a person could buy an insurance policy on the way to the hospital to deliver a baby.

REP. BARNHART said that is not what she wants, but that when a person buys an insurance policy they have to disclose medical conditions. She said that if a pregnant woman is on the way to the hospital everybody is going to know that she is pregnant.

Ms. Clifford stated that if you have an "ordinarily prudent" person clause then it is more likely that situations will go to court. She indicated that if a person has knowledge of a condition, and lies on the insurance policy, then that would be a breach of contract. She stated that with this phraseology, "you are helping the person who doesn't have knowledge of their condition."

REP. SIMON indicated that early pregnancy is not outwardly evident. However an woman could obtain health insurance knowing that she is in fact pregnant; which could potentially result in a some very high costs if there are any complications.

VICE CHAIR TUSS referred to amendment 3, subsection (b) in regard to "ordinarily prudent" and asked Mr. Hopgood if this language was used to prevent fraud.

Mr. Hopgood said essentially that would be correct.

VICE CHAIR TUSS stated that usually the delineations would be clear regarding "ordinarily prudent" and that only a small number of cases would have questions raised by subsection (b). She asked Mr. Hopgood if that were correct. Mr. Hopgood said yes.

VICE CHAIRMAN TUSS asked if Mr. Hopgood would be in favor of striking subsection (b) in favor of "a condition for which the individual was advised to pursue medical care during the preceding two years," and if that would answer some of the fraud concerns?

{Tape: 3; Side: 2.}

Mr. Hopgood stated concern for that statement, as an individual could have almost crippling headaches for six months, for example, and not seek medical attention, then apply for health insurance and be asked "have you seen a doctor within two years for any condition?" The answer would be no. "The language that you've just suggested would not bring that person within the statute." He stated that it is necessary to have "ordinarily prudent" or "reasonably prudent" language in there in order to prevent "gaming of the system."

VICE CHAIRMAN TUSS said that she understood and that his example is very clear and that it would not fall under subsection (b). She provided an example where an individual goes through their normal daily activities and then one day the individual feels a little tired. The individual doesn't hardly notice this, but thinks that maybe an extra nap during the day will help. And then the individual thinks this is really different from the way their body felt or their life's activities were 2½ years ago. And that individual goes to the doctor and finds out that they have some chronic condition such as leukemia or cancer. But, over time the individual's mind and body adapted to those changes because they were so subtle. You might think that an "ordinarily prudent" or "reasonably prudent" person with a major diagnosis like cancer might have sought medical evaluation, except that the symptoms were so subtle that the individual adapted to them. VICE CHAIRMAN TUSS asked Mr. Hopgood how that situation would fit into subsection (b).

Mr. Hopgood stated that in that situation she described a factual pattern which would not cause a "reasonably prudent" person to seek medical advice.

VICE CHAIRMAN TUSS inquired of Mr. Hopgood if in his mind there are examples of things that would not fall into this subsection. Mr. Hopgood said that is correct.

VICE CHAIRMAN TUSS referred to the discussion about a woman knowing she's seven months pregnant but if she's two weeks pregnant she may not know. She asked what possible difference does it make when at the end she has an infant, and that gestational age is documented in the medical records. "Does it matter when you know or can predict or assess what the gestational age of that lifebirth may be?"

Mr. Hopgood stated that evidence would certainly demonstrate whether or not the pregnancy existed on the effective date of coverage. He stated that is why that date is there.

VICE CHAIR TUSS said, "I'm just curious. What would happen if you took it out and relied on hospital records? Why would that automatically give an exclusion when gestational age would almost automatically tell you where you were, and whether there was fraud or misrepresentation?"

Mr. Hopgood stated he was not sure that he understood her question.

VICE CHAIR TUSS said she was curious as to why it is necessary to leave that exception in, when if there was fraud or deliberate deception it could be determined by the gestational age recorded in hospital records.

Mr. Hopgood asked why it shouldn't be in there. VICE CHAIRMAN TUSS indicated that she was asking him.

REP. SIMON said that the purpose of amendment 3, subsection (c) being specific about pregnancy is because a pregnancy usually lasts nine months. He indicated that amendment 3, subsection (b) refers to the last three years. He indicated that pregnancy needs to be noted because it is only a nine-month event. "It just says if you are pregnant prior to getting coverage, you are not covered for pregnancy. The gestation period would be very strong evidence as to whether or not you were pregnant prior to or after the coverage was obtained. He indicated that this was very clear language which allows the use of the gestational period to determine whether or not an individual was pregnant prior to obtaining coverage.

REP. SIMPKINS stated that if it were deleted, and an individual was pregnant at the time that coverage was obtained. He inquired where else does it say in the policy that it is void?

REP. BARNHART stated that when an application for insurance is made, the applicant is supposed to disclose and existing conditions and a woman is asked if she is pregnant.

REP. BARNHART asked Ms. Clifford if a person takes out a policy, don't they ask if an individual has a preexisting condition.

Ms. Clifford said yes.

REP. BARNHART asked what happens if a woman knows that she is pregnant but lies on the application?

Ms. Clifford said that it would be a breach of contract. It would be a close case if it were within a few weeks, and the policyholder would probably argue that they did not know of the pregnancy. However, if it were within a reasonable time period that an individual should know of the pregnancy, there could be a breach of contract.

REP. NELSON discussed the preexisting condition exclusion and said a preexisting condition is something that was not listed on the application that the person knew about.

Mr. Kunik stated that if a person applies for coverage and answer no on the pregnancy question. Then prenatal claims are submitted. If the doctor says that the time of conception was

either three days before the coverage or three days after the coverage, there is room for question on the actual date of conception.

Mr. Kunik commented that a "reasonably prudent" person refers to "something that actually happens that you can see, or feel, or what have you, that would cause to get medical attention."

REP. SMITH commented on the gestation period.

REP. KASTEN asked, "How often is a health plan issued and there is no waiting period?"

REP. NELSON stated that it depends on the company. He said probably not very often, and gave an example.

REP. KASTEN asked if companies issue a policy without any waiting period, can that policy be used the day the policy was purchased. REP. NELSON said yes.

REP. SIMPKINS said that the insurance company has the right to only look back five years in the medical records to see if they have sought medical attention for a health condition.

REP. KASTEN discussed pregnancy and preexisting condition.

REP. SIMPKINS said that pregnancy does not apply to the 12 month preexisting. He stated that if an individual has had a heart attack in the past, and then has a heart attack within 12 months of application, the insurance company has a right to look at the individual's medical records.

REP. R. JOHNSON inquired what the Committee was voting on.

VICE CHAIR TUSS said the Committee is voting on Amendment 1, numbered 1 through 7, submitted by REP. ORR. There have been no substitutes in the language.

Vote: Voice vote was taken. Motion carried 8 to 3 with REPS. SQUIRES, BARNHART, TUSS voting no.

Motion/Vote: REP. ORR MOVED HB 446 DO PASS AS AMENDED. Question was called. Motion carried 9 to 2 with REP. SQUIRES AND REP. BARNHART voting no.

EXECUTIVE ACTION ON HB 466

The chair was returned to CHAIRMAN ORR.

Motion: REP. SIMON MOVED TO AMEND HB 466, PAGE 1, LINE 27, AND STRIKE "INCLUDING" AND INSERT "EXCLUDING".



## HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Page 1 of 3

Mr. Speaker: We, the committee on Select Committee on Health Care report that House Bill 446 (first reading copy -- white) do pass as amended.

Signed: \_\_\_\_\_

A handwritten signature in dark ink, appearing to read "Sf Orr", is written over a horizontal line.

Scott Orr, Chair

And, that such amendments read:

1. Title, line 5.  
Strike: "INDIVIDUAL"

2. Title, line 6.  
Strike: "33-22-101"  
Insert: "33-22-110"  
Following: "; AND"  
Strike: through "MCA"  
Insert: "PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE  
APPLICABILITY DATE"

3. Page 1, line 10 through page 2, line 17.  
Strike: sections 1 through 3 in their entirety  
Insert: "Section 1. Section 33-22-110, MCA, is amended to read:  
"33-22-110. Preexisting conditions. (1) A Except as  
provided in subsection (2), a policy or certificate of disability  
insurance may not exclude coverage for a condition for which  
medical advice or treatment was recommended by or received from a  
provider of health care services unless the condition occurred  
within 5 years preceding the effective date of coverage of an  
insured person. The condition may only be excluded for a maximum  
of 12 months.

(2) A health benefit plan may exclude coverage or limit  
benefits for a preexisting condition for a maximum of 12 months.  
A health benefit plan may not define a preexisting condition more  
restrictively than:

Committee Vote:

Yes 9, No 2.

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(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 3 years preceding the effective date of coverage of the insured person;

(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or

(c) a pregnancy existing on the effective date of coverage of the insured person.

(3) For purposes of subsection (2), a "health benefit plan" means a hospital-incurred or medical expense-incurred policy or certificate, a subscriber contract, or a contract of insurance provided by a health service corporation or a health maintenance subscriber contract.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards."

NEW SECTION. Section 2. Riders. Except for a policy issued under chapter 22, part 18, a policy of disability insurance may exclude coverage for specific conditions through the use of elimination riders. Except for a policy of disability income insurance, a condition excluded by an elimination rider may be excluded for a period not to exceed 5 years from the effective date of coverage of the insured person."  
Renumber: subsequent sections

4. Page 3, line 26.

Strike: "[section 2]"

Insert: "33-22-110(2)"

5. Page 5, line 6.

Strike: section 5 in its entirety

Insert: "

NEW SECTION. Section 4. Retroactive applicability. [Section 2] applies retroactively, within the meaning of 1-2-109, to policies, certificates, or contracts of disability insurance issued prior to [the effective date of this act], except for policies, certificates, or contracts issued under Title 33, chapter 22, part 18.

NEW SECTION. Section 5. Effective date. [This act] is effective on passage and approval."

Renumber: subsequent section

6. Page 5, line 8.

Strike: "Sections 1 and"  
Insert: "Section"  
Strike: "are"  
Insert: "is"

7. Page 5, line 9.  
Following: "chapter 22," in both places  
Insert: "part 1,"

-END-

Amendments to House Bill No. 446  
First Reading Copy

Requested by Representative Scott Orr  
For the Select Committee on Health Care

Prepared by Susan Byorth Fox  
February 15, 1995

1. Title, line 5.  
Strike: "INDIVIDUAL"

2. Title, line 6.  
Strike: "33-22-101"  
Insert: "33-22-110"  
Following: "; AND"  
Strike: through "MCA"  
Insert: "PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE  
APPLICABILITY DATE"

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Strike: sections 1 through 3 in their entirety  
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provider of health care services unless the condition occurred  
within 5 years preceding the effective date of coverage of an  
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of 12 months.

(2) A health benefit plan may exclude coverage or limit  
benefits for a preexisting condition for a maximum of 12 months.  
A health benefit plan may not define a preexisting condition more  
restrictively than:

(a) a condition for which medical advice, diagnosis, care,  
or treatment was recommended or received during the 3 years  
preceding the effective date of coverage of the insured person;

(b) a condition that would have caused an ordinarily  
prudent person to seek medical advice, diagnosis, care, or  
treatment during the 3 years preceding the effective date of  
coverage of the insured person; or

(c) a pregnancy existing on the effective date of coverage  
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elicit the complete health history of an applicant and, on the  
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accordance with the insurer's established underwriting  
standards."

NEW SECTION. Section 2. Riders. Except for a policy issued under chapter 22, part 18, a policy of disability insurance may exclude coverage for specific conditions through the use of elimination riders. Except for a policy of disability income insurance, a condition excluded by an elimination rider may be excluded for a period not to exceed 5 years from the effective date of coverage of the insured person."  
Renumber: subsequent sections

4. Page 3, line 26.  
Strike: "[section 2]"  
Insert: "33-22-110(2)"

5. Page 5, line 6.  
Strike: section 5 in its entirety  
Insert: "

NEW SECTION. Section 4. Retroactive applicability. [Section 2] applies retroactively, within the meaning of 1-2-109, to policies, certificates, or contracts of disability insurance issued prior to [the effective date of this act], except for policies, certificates, or contracts issued under Title 33, chapter 22, part 18.

NEW SECTION. Section 5. Effective date. [This act] is effective on passage and approval."  
Renumber: subsequent section

6. Page 5, line 8.  
Strike: "Sections 1 and"  
Insert: "Section"  
Strike: "are"  
Insert: "is"

7. Page 5, line 9.  
Following: "chapter 22," in both places  
Insert: "part 1,"

MINUTES

MONTANA SENATE  
54th LEGISLATURE - REGULAR SESSION  
JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By CHAIRMAN STEVE BENEDICT, on March 9, 1995, at  
5:30 p.m.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)  
Rep. Scott J. Orr, Vice Chairman (R)  
Sen. Mike Foster (R)  
Rep. Duane Grimes (R)  
Sen. Judy H. Jacobson (D)  
Sen. Ken Miller (R)  
Rep. Bruce T. Simon (R)  
Rep. Carolyn M. Squires (D)  
Rep. Carley Tuss (D)

Members Excused: Sen. Dorothy Eck (D)

Members Absent: None

Staff Present: Susan Fox, Legislative Council  
David Niss, Legislative Council  
Jennifer Gaasch, Committee Secretary

Please Note: These are summary minutes. Testimony and  
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: This was a meeting where public  
testimony was given on HB 446, HB 531,  
HB 533, SB 322, SB 341, HB 85, HB 202,  
SB 62, SB 74, and SB 376

Executive Action: None

[Tape: 1; Side: A.]

Public Testimony:

Kate Cholewa, representing Montana Women's Lobby, said on HB 446, page 3, defined at the top of the page "A health benefit plan may not define a pre-existing condition more restrictively than these items." In (b) it talks about an ordinarily prudent person seeking medical advice. On (c) they have pregnancy existing on the effective date of the coverage of the insured person. She said they would like to see pregnancy not treated any differently than other pre-existing conditions. An ordinarily prudent women

if they trace her date of pregnancy back to a week before her policy went into effect she is an ordinarily prudent person with a pre-existing condition who would have still sought medical advice for that condition. They would like to see pregnancy not treated differently.

Tom Hopgood, representing the Health Insurance Association of America, said he would like to address HB 446 and had amendments they would like to offer to that bill. (EXHIBIT #1) He said the amendments were mostly technical. On line 5, page 3, they think that would be a good idea to strike that so they do not write a pre-existing condition on pregnancy. He said the bill sets a pre-existing condition for a health benefit plan, look back for 3 years, exclude it, then for a period of 12 months. It is a little better than it is for other types of disability policies which are on the market. He said he had some amendments to propose. (EXHIBIT #2) He said this bill said once a pre-existing condition is covered under a health insurance policy they, can transfer their health insurance policy to another company and they would not have to satisfy the pre-existing condition again. There is a provision in HB 533, Section 3, page 2, which would address the spread of premium increases. When a person becomes ill some health insurance companies have taken that person's premiums and increased them because of adverse claims experience. In Section 3, the only thing that should increase an individual's policy is an increase in his/her age. Any other reasons to increase that policy have to spread across the entire market. The company cannot take revenge on a person for getting sick. The way the bill was originally written it would apply to group policies. The thought was that group policies were already sufficiently covered under the small group act. He said the amendments would take care of that. He said they had one amendment prepared for HB 531. (EXHIBIT #3) He said that amendment was on page 7, line 30, and has to do with the disclosure requirements. Health care insurers and producers are to provide, at the point of application, a set of materials continuing on page 8. They think that is a lot of material. What it appears they really want is a general history of what is going on with the premiums to particular policies. They feel by the company providing a general narrative of what has gone on with the companies premiums over the past 5 years would be sufficient for that. He said they were still discussing things between the interested parties.

Claudia Clifford, representing the State Auditor's Office and the Commissioner of Insurance's Office, said was going to address HB 446, HB 533, and SB 322. The goal is to address portability. The key to understanding portability is whether or not they can even get their next policy. She said that is what the issue of guaranteed issue is about. These bills deal with pre-existing conditions. She said in current law, a pre-existing condition is a problem that has occurred, there is a medical diagnosis, it is something that is documented. In one of the bills they add a definition of what pre-existing means. It would be what any

prudent person would have sought treatment for. That makes it more difficult for the consumer. It is hard for them to seek recourse if they disagree with the insurance company. It is not in the best interest. There is the look back period issue. How far back in someone's history do they look back and say this is a condition which they are either not going to cover or treat differently. In current law it is a 5-year look back period. One of the bills says they would only look back 3 years, but it then deals with rider conditions. It segregates some of the pre-existing conditions. It says that some pre-existing conditions are bad enough that they will not only apply a 12 month waiting period, but they want to note those conditions in the contract and make them wait longer on getting coverage for that. That kind of rider condition in one of the bill says that they will not cover those conditions for 4 years. The insurance company would argue that if they could not rider some conditions, especially in individual policies, they would probably choose to reject that person all together. Riders are not currently dealt with in law. Riders are not allowed because they are not dealt with and all the law says is that if a person has a past medical problem they can only have a 12 month medical problem. They need to deal with riders somehow if they are going to be allowable. If a person has a condition that has not been ridered, the bills have what is an attempt to waive the 12 month waiting period. If a person has had previous coverage and they did not have much of a lapse in coverage they do not have to go through the 12 month waiting period. That is very important for portability and as a good move in the bills. One bill says that the lapse in coverage can be only 30 days and another bill says 60 days. There is also a difference as to when that applies. They recommended they put in the 60 days and that they make it to that date of application. The day of application is controlled by the consumer. Companies vary on how quickly they can issue policies. She said if the idea was not to restrict any more on a person when they are going to their next policy then riders do not do that. Currently, if they leave the bill unamended, insurance companies can look back in someone's past history back to birth and rider any condition. They recommended that they apply the same look back period to ridered conditions as they do to the other pre-existing conditions of 3 years. They acknowledge that there is a complex issue of riders when they move to another policy. Companies have different underwriting policies. The new company may want to rider a whole new set of conditions. When they had the first policy there was only one ridered policy and when they go to the next policy there may be 4 or 5 different riders. Do they want to allow that or do they want to address that there would be no more riders in the next policy. In response to a question regarding which bill she was referring to, **Claudia Clifford** replied essentially she was talking about all three bills at one time. She said they support the concepts in all three bills of improving pre-existing conditions and improving portability. She said with the issue of riders when going to a new policy they want to allow consider that if they have a rider condition on their first policy for 4 years and they have had that policy for

2 years, when they go to the new policy do they receive the same kind of credit that they got from pre-existing conditions and they only have to fulfill 2 more years of a rider condition. She said, dealing with the retroactive applicability of a bill they believe to retroactively to allow for riders is unconstitutional under contract law. She said she had a copy of the GOP health plan in the news. (EXHIBIT #5) She offered amendments to SB 322 (EXHIBIT #5), HB 446 (EXHIBIT #6), and HB 533 (EXHIBIT #7).

Larry Akey, representing the Montana Association of Life Underwriters, said they supported HB 446 and HB 533 when they were before the House Select Committee on Health Care. They support the amendments proposed by Tom Hopgood. He said it is true that an ordinarily prudent person does add a new standard or reintroduces a standard to the statute on pre-existing conditions. He said they did not feel that was a necessary part of the statute when the look back period was 5 years. They felt it was important to bring that standard back in if they were going to change the look back period to 3 years. They believe the rider language as it is currently contained in HB 446 as amended in the proposed amendments by Tom Hopgood are good and solid rider exceptions. He said there was an issue of retroactivity. That is a danger that a force to find a retroactive application of the statute unconstitutional. However retroactive applicability does solve a major problem that was in the market and will remain in the market. Riders were commonly used in insurance policies prior to a departmental interpretation about 1 ½ years ago. There are a number of policies out there today that have riders on them. They are concerned without retroactive applicability that an insurance company in the future find itself in court over that rider. They suggest a better way would be to not strike the section on retroactive applicability and the question of its constitutionality is to add a section on severability. They think that would address the issue should the courts find that they cannot retroactively apply those provisions they would not have to throw out the entire statute. They support tax deductibility of insurance premiums. They asked that they treat individual premiums, premiums written by self-employed individuals in the same way they would treat health insurance premiums in a corporation or another business. They would like to see health care treated as a deductible expense from the first dollar across the board, but that would be very expensive. It is up to this committee and this Legislature to see how much tax fairness they can afford in the area of health care. He said HB 202 was the bill that addresses insurance premiums. They would at a minimum ask that they address HB 202. SB 376 is an effort to regulate multiple employer welfare arrangements (MEWA). He said there are two reasons that insurance agents care about the regulation of multiple employer welfare arrangements. One is that they have a direct impact with the way they do health care reform in the state of Montana. The tighter things are in the regulated market, the higher they raise the limit on the number of employees in a small employer group under the small employer act. He said the more likely it will be that they will see

leakage into the self-funded market because those self-funded plans are exempted from mandated benefits and other provisions of the state insurance code. He said to the extent that they have multiple employer welfare arrangements out there that are not regulated or are very weakly regulated they are concerned that any efforts they make to provide health care reform will only end up forcing people into the unregulated market and escaping all of the things the Legislature currently is trying to accomplish. Insurance agents that market products for unregulated MEWAS may be exposing themselves financially since they are selling products for what is essentially an unauthorized insurer. Their A and O coverage probably will not cover the consequences of any financial insolvencies. It is important for the agents who are offering MEWAS that they have some sort of regulation on the books so that exposure is not there. He said that SB 376 was considered the great compromise. He said there were 2 groups that were not involved in striking that compromise. There are groups that might like to form MEWAS, but under that bill they would be prohibited. Insurance companies and insurance agents were also not involved. He asked that they give SB 376 some scrutiny. He said the supporters of SB 376 would have the people believe that they did not have to accept any form of regulation and that ERISA wipes out any efforts of the state to regulate multiple employer welfare arrangements. He said it is true that they cannot touch a single employer self-funded plan. He said ERISA says they cannot touch fully-insured MEWAS. He said they cannot regulate them except by regulating the insurance companies that provide them insurance. They cannot touch MEWAS that have been exempted by the Secretary of Labor and there are none of those in Montana. They cannot touch MEWAS that are also employee welfare benefit plans. ERISA defines what an employee welfare benefit plan. MEWAS that are not also employee welfare benefit plans can be regulated by state insurance codes. They supported SB 376 in the Senate with promise to work to strengthen it. There are three areas that the committee should look at. SB 376 sets up a dual track. It says that 4 MEWAS that currently exist. For MEWAS asking for a certificate of authority do not have to comply with demonstrating to the commissioner that they are financially solvent. New MEWAS do have to do that. SB 376 sets up a bona fide association as one of the requirements of being a MEWA. That says they can not form a new bona fide association and create a MEWA for 5 years. The bill creates certain exceptions and exemptions from the insurance laws. The compromise does provide some coverage by the insurance laws. He said on page 8, section 14, title 33, chapter 8, of SB 376, they say that they are going to comply with that except for the fact that they do not want to comply with 33-18-242. 33-18-242 is the section of the statute that gives an individual that has been injured by an insurance company an independent cause of action. They think if it is good for the insurance companies it is good for multiple employer welfare arrangements that are not also employee welfare benefit plans. They ask that they would also consider extending some of the sections of the insurance code to MEWAS. They have said in SB 376 that they are willing to subject

themselves to examinations, but not to approval of forms. It seems that they need both. They exempt themselves from contract language. One of the sections they are willing to comply with is privacy and information chapter. All of those are things the committee should look at and they would submit amendments in those areas. They think there should be some disclosure to the people who are receiving their health care through multiple employee welfare arrangements. They think a MEWA should disclose on the face of the policy or contract that it has with its insured that it is a multiple welfare arrangement that is not an insurance company and that it is not covered by all the guarantees of the statute affecting insurance companies and it is not covered by the guarantee association. He said they are issues they need to address if they are going to report out SB 376. They can either make it clear that SB 376 only applies to those MEWAS that are also employee welfare benefit plans and that all the laws of insurance in Montana affect those MEWAS that are not also employee welfare benefit plans or they can work to tighten up SB 376 in the ways he recommended.

Susan Good, representing Heal Montana, read her written testimony. (EXHIBIT #8)

Tanya Ask, representing BlueCross BlueShield of Montana, said they supported HB 446 and agree with the proposed amendments. They support HB 533 and agree with the proposed amendments. She said riders were important because in the individual market place is not a guaranteed issue market place. Riders allow individuals that might not get coverage to be able to get coverage for everything else except that ridered issue. She said they supported the retroactive applicability. They feel there are problems due to the way that particular provision had been interpreted over the last year. She said she would like to comment on having portability of the riders. She said under riders, those individuals are not guaranteed issue. Even though that would allow portability in the individual market it does not say that say that an insurance company would necessarily going to take that risk. Insurance companies have different underwriting criteria. One may accept someone with a rider and another may not accept that without a rider. She said she said the Comprehensive Health Care Authority is a pool of last resort. They have been in the process of making the benefits better under state law. She said they were trying to move those benefits up. She said that they would like to do that and they are asking to keep the potential cost in mind. They would like SB 341 that contains other provisions that the board felt changes were necessary to in order to make the operation more viable. Tax deductibility will be decided on the overall financial constraints on Montana. She said they have endorsed HB 202 dealing with strictly the deductibility of premiums for individuals. She said this was an area of concern by small businessmen who had their own individual contracts. They would like the same benefit as larger groups have. She said they would support SB 376 with the attached amendments. They would like those types of arrangements to be on

equal footing. There are already new potential to be on equal footing with those already in the self funded multi-employee welfare arrangement market place. The amendments provide basic protection such as privacy protection, newborn coverage and other things that Montana's previous legislatures have felt were important. ERISA qualifying MEWAS are precluded from some portions of state law, but not every single MEWA is.

*{Tape: 1; Side: B; Approx. Counter: .1; Comments: Tanya Ask was cut off while she was talking.}*

She said this legislation grants a certificate of authority. That is a license to be an insurer. When they are licensed as an insurer, consumers think it is an insurance company that is subject to all of the regulations of the state and the protection are afforded thereby. She said they were concerned with the certificate of authority. She asked that they take a look at the way it was written because they feel it may preclude some people from becoming a MEWA until they have been a bona fide association for a period of 5 years. She said there are things that people feel they cannot live with under the insurance regulation. She said one of those things was a form filing requirement. The insurance department reviews the benefit agreements that Montana consumers would receive. Another was how the contract would be laid out so that people would have an idea what the benefits under that contract would be. Another was a law that regulated how insurance companies, health service organizations, HMO's, and others conduct utilization review. She said there were very strict requirements put on there for the benefit of Montana consumers. They asked that the particular set of amendments be given careful consideration.

Tim Filz, a attorney with the Brown law firm in Billings and represents an number of MEWAS, he said he would talk about SB 376. He said a MEWA was a Multiple Employer Welfare Arrangement. Any time two or more employers get together and provide welfare benefits for their employees that is a MEWA. He said the exception to that is if the employers are related or controlled entities. He said ERISA says that state law cannot regulate employee welfare benefit plans. ERISA says that notwithstanding that prohibition states can regulate insurance companies. The states can heavily regulate insurance companies even though there is an impact on a welfare benefit plan. Any employer that adopts a plan to provide health benefits for its employees is a welfare benefit plan whether that is fully insured or self funded. The state or the federal government says that Montana cannot directly regulate any employer to the extent that they provide welfare benefits to their employees. The federal government says that the state can regulate the insurance companies. The federal government says that the states can regulate multiple employer welfare arrangements to the extent that those requirements are not inconsistent with ERISA. ERISA says that under no circumstances can the state label, call, or describe a welfare benefit plan as an insurance company. That means if they have a

welfare benefits plan, it is not an insurance company and it can not be regulated as an insurance company. A single employer or certain types of multiple employer plans are also welfare benefit plans. He said the MEWA bill in defining what entities are allowed to register as MEWAS is limited to those kinds or arrangements which would qualify under ERISA as welfare benefit plans. A welfare benefit plan which would involve multiple employers is limited to arrangements that are either single industry, or if there is a bona fide employment-related bond between the employers. He said if there is that kind of relationship, then they would be a welfare benefit plan under ERISA entitled to ERISA pre-emption.

ERISA says you can regulate MEWAS if they do not violate ERISA and if they are not called insurance companies. That is the reason they allow a little bit of regulation, not a lot. He said they can be regulated if they are done consistent with the fundamental concepts and not inconsistently with ERISA. With the MEWA legislation they have defined what MEWAS are which is not currently done. They provide for a certification process. MEWAS that do not come through the process are going to be ruled unauthorized insurers. The bill provides for minimum reserves and for minimum funding. That is very crucial. It provides for reporting requirements. The act provides for penalties for MEWAS that do not comply and provides for remedies in the form of liquidation procedure for a MEWA. They agree to that regulation because it will ensure that only good, viable, healthy MEWAS exist. He said there is a dual tract because there are a number of MEWAS out there and they are not sure how many individuals are being provided benefits under existing MEWAS. They think that by coming up with some rules, such as an association must be in existence for at least 5 years prior to sponsoring a MEWA. They think that is a sound rule, but would like it to be around 2 or 3 years. They exempted existing MEWAS because if there is a MEWA that was formed 4 ½ years after the association was formed and was providing benefits to 500 individuals, are they going to say that they were going to disallow that MEWA that otherwise would meet the requirements. He said they need to say that the ones that were in existence before then can meet the requirements they will allow them to exist. They do not want to encourage the rush to form MEWAS. They are not strongly against disclosure. He said the kind of language in 33-11-1047 with respect to risk retention groups is probably an appropriate type of language to use. He said that they did agree to have all of the Fair Practices Act provisions incorporated into the MEWA bill except for the private cause of action. That is because ERISA provides a private cause of action for individuals agreed by a welfare benefit plan. He said the states can regulate MEWAS, but if it is inconsistent with ERISA. ERISA provides a comprehensive private cause of action and in having done that it is inconsistent for the state to have to create an independent private cause of action. There are things that are allowed under ERISA that are not allowed under a claim against an insurance company.

Lloyd Lockrem Jr., representing the Montana Contractors Health Care Trust, said he would like to address section 33-18-242. He said the primary function of ERISA is to protect the participant once an employer has decided to have employee benefits. He said ERISA does require full disclosure. He said "U.S. district courts have exclusive jurisdiction over civil and criminal action brought under Title 1 of ERISA. Except that cases pertaining to benefit recovery brought by participants may also be brought in state courts. U.S. district courts have jurisdiction to grant relief without respect to the amount in controversy or the citizenship of the parties. The court may decide who shall pay the court costs and legal fees. If you as a participant are successful the court may order the person you have sued to pay these costs. If you lose the court may order you to pay these costs and fees for example that finds your claim frivolous. In addition to creating rights for the plan participant, ERISA imposes duties upon the people who have the responsibility for the operation of the employee benefits plan. The people who are on the plan are called your fiduciaries of the plan and have a duty and in the interest of you and other planned participants. No one else including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA." He said they have set up a review procedure and each time they sit, they sit not as an employer, but as a trustee representing the participant. Legal action to recover lost benefits under this plan may not be brought until they have gone through the administrative procedure. They do not have to appear, but they always have that right. He submitted if and when the insurance industry provides employee benefits at affordable costs to employers in Montana who genuinely want to provide benefits, particularly health care, MEWAS will go away. He said they would commit to the committee if there was any possibility to resolution between the parties they would pledge to work towards that.

Jerry Driscoll, said he had heard a statement made that it was not known if there was any plan approved by the Secretary of Labor. Under the definition, collectively bargained, or by rural electric, or by rural telephone cooperatives are exempted from any state regulation. There are probably 29 of them so far that were approved by the United States Secretary of Labor. He said MEWAS work best when the group of employers form this and then they provide health insurance to their employees and there is portability between the employers because of the skills normally needed by those employers and the employees of anyone can transfer within that. It does not matter what the employer is, it is the skill that they want. The insurance is then portable between the employers. He said there should be some commonality of the employers.

**CHAIRMAN BENEDICT** replied that he understood there were some amendments that people would like to propose and they would like to have the amendments before executive action.

**Lloyd Lockrem** replied they would get them the amendments as soon as they could. He said he was trying to resolve an issue that has been in there.

**Diane Ruff**, representing Associated Employers of Montana, read from a handout. (EXHIBIT #10)

**Gary Spaeth**, the Chief Council at the State Auditor's Office, said the MEWAS they had come in contact with serve the people well. There are some that are not in Montana that have caused problems. When a MEWA goes insolvent that is where the problem occurs. He said that was what the bill was set up for. How to insure solvency. He said there is a MEWA scam business in other places. He said they were concerned if they did not have some control, it would happen in Montana. He said there are 22 cases that are the leading cases that are in a small area. He said they could either proceed to litigate a lot of issues or they could have a chilling effect. The major concern was solvency. He said the bill does what they set out to do. He said they did not want to seek to have extensive regulation for the fact that they are not in a regulatory climate. He said they looked at approval of forms and paper concerns which are important ways to regulate, but they are not equipped with staff to do that. He said this was a good starting point on regulating MEWAS. He said they do not even have a list of the MEWAS in Montana. He said the amendments (EXHIBIT #11) have been approved. He said they need a statement of intent because they set up a solvency standard, but if they become insolvent they did not put in the liquidation provisions of the statute and they have to adopt them by rule. The other provisions allow flexibility.

**Bob Turner**, representing the Department of Revenue, said he would address tax deductibility which included HB 85, HB 202, SB 62, and SB 74. He said he would like to give an idea of what is presently allowable in Montana law. (EXHIBIT #12) He addressed each bill and gave amendments that included an explanation of the amendments at the bottom of the page. (EXHIBITS #13-16)

**Rick Larson**, representing EBMS, said his company is Employee Benefit Management Services and they are in the business of administering employee benefit plans for single and multiple employer welfare arrangements. He said a lot of the protection comes under the Department of Labor and under ERISA. He said a lot of the things that are not covered in the bill are covered under federal law. He urged the passage of the bill with minimal amendments.

**REPRESENTATIVE PEGGY ARNOTT**, HD 20, said she was the sponsor of HB 533. She said in HB 533 the premium increases must be

distributed proportionably. She said insurers would not be able to selectively raise premiums on one individual with health problems. They would have to distribute the premium increases proportionally. It would make it so no one would be penalized for getting sick. She said the requirement that an individual has qualified for an insurance once they have done that and maintained coverage they do not have to go through another qualifying period. This bill is a small step forward. The 30 days was amended in committee. She said that was an acceptable length of time as amended.

Ed Grogan, representing the Montana Medical Benefit Plan and the Montana Medical Benefit Trust, said they Montana Medical Benefit Trust was a fully insured MEWA and the Montana Medical Benefit Plan provides the insurance for that MEWA. He said there are reams and reams of federal legislation and Department of Labor rules on MEWAs and before they were to make any dramatic changes, they should have a lawyer check to make sure they were not violating laws. He said the present law as in 33-22-110 says it is not a pre-existing condition unless they have seen a doctor. He said people are sick before they go see a doctor. The new rules allow for a ordinarily prudent person would determine whether or not the condition was pre-existing condition when filling out their application. The problem with waiting to see a doctor is they have had 3 claims that they have had to pay in the last year because it is only in the last year that it has applied. He said the law as it stands lets people with pre-existing conditions purchase insurance. He said previous to this year riders had allowed in Montana. They have said that riders and pre-existing condition are one in the same and they could only have a rider for 1 year. The changes are to make it so that they could not have riders. The law says 4 years and they believe that there should be no limit on the length of time for a rider. He said to put a 4 year limitation on a rider would be the same as saying that they would have to deny that person coverage. He said the new language in the bill that says a person can basically go 60 days without insurance and then sign an application should say that they be out of the market only 30 days and if they have an application within that 30 days period they would still be qualified. They support tax deductibility and any bill pertaining to that.

EXHIBIT #17 was passed out to the committee.

CHAIRMAN BENEDICT said he would open it up to anyone who wanted to address health care in general.

Tanya Ask, representing BlueCross and BlueShield of Montana, said she would like to address cost containment and early intervention and prevention. A group of people who have not been present are children who are not insured and not covered by Medicare or Medicaid. The Caring Program for Children sponsored by the Caring Foundation of Montana. This program is a private effort that is a cooperative effort on the part of physicians,

hospitals, insurance agents, physician assistants, nurse practitioners and the whole health care community as well as individuals and groups around the state. She said the program was a non-profit program which was started 1 ½ years ago. She said the idea was that frequently children do not receive primary preventive health care benefits when their parents are in transition. The program provides benefits for well child visits, regular office visits, x-ray lab services, and out-patient surgery. It is not designed to be 100% coverage, but it is designed to take care of most of the services that most children need. The cooperation of health care providers is important because those who participate in the program receive a lower level of reimbursement to cover the children. They know that they are going to be paid for taking care of that child, they will not have to worry about deductibles or co-payments, and that takes care of an administrative burden. This program has provided benefits for over 600 children in Montana. The reason they are bringing the program to the committee is to notify them that the more dollars that come in the more they have to help the children. They are bringing the idea of a public private initiative. The idea would be to have a match and that there are so many public dollars before private dollars are put in.

Jeffrey H. Strickler, M.D., read his written testimony.  
(EXHIBIT #18)

{Tape: 2; Side: A.}

CHAIRMAN BENEDICT said that there was not a vehicle for this issue in the legislature. The wisdom of the people that chose the bills that came into this committee were such to take the bills that were alive in the process. He said that these presentations could best be made to the appropriations committee if SENATOR DOROTHY ECK'S bill made it to that process. He thanked them for making those concerns.

Questions from the Committee:

None

MONTANA SENATE  
1995 LEGISLATURE  
JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL

DATE 3-9-95

[illegible]

Exhibit #1  
3-9-95

HIAA/MALU/BC&BS  
AMENDMENTS  
HB 446

1. Page 3, line 1.  
Following: "person;"  
Insert: "or"
2. Page 3, line 4.  
Following: "person"  
Strike: "; or"  
Insert: "."
3. Page 3, line 5.  
Strike line 5 in its entirety.
4. Page 3, line 6.  
Following: "hospital"  
Insert: "expense"
5. Page 3, line 7.  
Following: "policy"  
Insert: ", contract,"
6. Page 3, line 7.  
Following: "certificate"  
Strike: ", a subscriber contract or a contract of insurance"
7. Page 3, line 7.  
Following: "provided by a"  
Insert: "health insurer,"
8. Page 3, line 8.  
Following: "service corporation or"  
Strike: "a"
9. Page 3, line 8.  
Following: "health maintenance"  
Strike: "subscriber contract"  
Insert: "organization"
10. Page 3, line 14.  
Following: "INSURANCE MAY"  
Strike: "EXCLUDE"  
Insert: "contain a provision which excludes"

11. Page 6, line 13.

Insert:

"NEW SECTION. Section 5. Severability.  
If a part of [this act] is invalid, all valid  
parts that are severable from the invalid  
part remain in effect. If a part of [this  
act] is invalid in one or more of its  
applications, the part remains in effect in  
all valid applications that are severable  
from the invalid applications."

12. Renumber subsequent sections.

State Auditor's Proposed Amendments to HB 446

1. Page 2, Line 25  
Following: "within".  
Strike: "5"  
Insert: "3"
2. Page 2, line 27 through page 3, line 8.  
Strike: page 2, line 27 through page 3, line 8 in their entirety
3. Page 3, Line 14.  
Following: "MAY"  
Insert: "contain a provision which"
4. Page 3, Line 14.  
Following: "EXCLUDE"  
Insert: "s"
5. Page 3, Line 14.  
Following: "CONDITIONS"  
Insert: "which occurred within 3 years preceding the effective date of coverage of an insured person"
6. Page 6, Line 9  
Strike: Section 4 in its entirety

Exhibit 107  
3-4-95

#### PRE-EXISTING CONDITIONS

The issues of portability and pre-existing conditions are important features of the HEAL Montana program. We support RS 533 and HB 446.

People need to be able to take their insurance with them as they change careers throughout their lifetimes. Being able to be "benched" for one waiting period should be sufficient, rather than the old ways of starting the clock over each time.

HEAL is interested in the amendments offered by the insurers, and we generally support them, but there is one glitch. Portability will be taken care of for individuals, groups from three to twenty five, and large groups. The segment unaddressed is the two person group. There seems to be no sympathy to lower group to two, and preliminary discussion reveals the difficulties that are peculiar to that set. Addressing that problem should probably be left to another time.

#### MCHA

MCHA needs serious attention. Its benefits are poor and the premiums exorbitant. Both sides need adjustments. Current premium rates are 150 to 400% of regular premiums. Surrounding states are capped at 125- 135%.

MCHA benefits and its programs were and will continue to be the subject of intense debate at the working meeting. *Support 2/1*

#### DEDUCTIBILITY

*#B 202*  
HEAL is supports Tax Deductibility for premiums for health insurance premiums.

M. SUSAN GOOD  
HEAL MONTANA  
JOINT HEALTH CARE COMMITTEE  
MARCH 9, 1995

Motion/Vote:

SEN. JACOBSON MOVED HB 466 DO PASS AS AMENDED. The MOTION CARRIED UNANIMOUSLY.

SEN. JACOBSON would carry the bill on the Senate floor.

EXECUTIVE ACTION ON HB 446

Discussion:

Rick Hill explained the amendments (EXHIBIT #5).

SEN. JACOBSON said she was still troubled about riders.

Rick Hill said a person buys insurance who has a condition that the insurance company is concerned about they can put a rider on that person's policy which would exclude that condition. A person would be insured for anything else that the policy covered, but not that condition. If they cannot put a rider on a policy it could preclude the insurance company from offering any insurance to that person.

SEN. JACOBSON said the amendments on the first page of EXHIBIT #5, #1 and on the second page where they are talking about riders on EXHIBIT #5, #7, have the same definitions. She said they could be doing something for pre-existing conditions and then the insurance companies could say that they were not covering it under pre-existing conditions they were covering it under riders because they had more flexibility under riders. Without a definition they were fixing it one place and causing trouble some where else.

CHAIRMAN BENEDICT said there was not unanimity among the group and there were a lot of different opinions of how riders should be treated and so they just let riders go.

REP. TUSS asked how riders affect portability.

Rick Hill replied the problem with portability of insurance is if a person had a rider on a policy that had a limit on that rider, and then the person went to another insurance company, would that insurance company be required to only fulfill the balance at the time of that rider, or would the rider start all over again. They could have a person with an unridered policy with one insurance company and if they went to another company and that insurance company wanted to put a rider on it would they have less insurance coverage.

REP. TUSS asked if she could characterize that riders complicate portability in the individual market.

Rick Hill said that either way they do it, it complicates it.

SEN. JACOBSON said she agreed with Mr. Hill that if they totally preclude riders they may preclude someone from getting an insurance policy. She said they had no difference in definition between pre-existing conditions and no limits.

REP. SIMON said if they look at amendment #7, on EXHIBIT #5, it says that 33-22-110 does not apply to elimination riders. He said the language on amendment #1, EXHIBIT #5, is codified under 33-22-110, they do not technically create a conflict between those two sections. Perhaps they need to have the word rider defined. He said the purpose of riders was to say that provision 33-22-110 say that they cannot have a pre-existing condition apply, but the price may be so high that they cannot afford it and they would choose to want to eliminate that coverage so they could make the rest of the coverage affordable to them so it was a customer choice. He said that perhaps a definition would be important.

CHAIRMAN BENEDICT asked if there was a definition of riders.

Rick Hill said that riders and pre-existing conditions deal with the same sort of circumstances. A rider is a part of the insurance contract itself and would be defined in that contract. Pre-existing conditions limitation would be an unridered pre-existing condition. If it is a ridered pre-existing condition then that would be defined.

REP. SIMON said may be they should have something in the definition section of what a rider is.

Rick Hill said that they have a definition of riders. He said an elimination rider was a division of policy which excludes coverage for a specific condition which would otherwise be covered under the policy.

CHAIRMAN BENEDICT said they would put that in conceptually.

Motion:

REP. ORR MOVED the amendments EXHIBITS #5 and #6.

Vote:

The MOTION CARRIED UNANIMOUSLY.

REP. SIMON offered a conceptual amendment to adopt the definition of riders.

Motion:

REP. SIMON MOVED to amend the bill with the definition of "elimination rider".

Discussion:

CHAIRMAN BENEDICT said that technically a rider is not part of a policy and that is why it is a rider. The language said it was part of the policy.

Rick Hill said that was not the case. That would be an amendment to the policy itself and therefore become part of the policy.

CHAIRMAN BENEDICT said the language read "elimination rider was a division of a policy".

Rick Hill said it should read "attached to a policy".

{Tape: 1; Side: B.}

Vote:

The MOTION CARRIED UNANIMOUSLY.

Motion/Vote:

REP. ORR MOVED HB 446 DO PASS AS AMENDED. The MOTION CARRIED UNANIMOUSLY.

SEN. MILLER would carry HB 446 on the Senate floor.

EXECUTIVE ACTION ON HB 533

Discussion:

CHAIRMAN BENEDICT said how does this bill differ from the HB 446.

Rick Hill addressed the amendments (EXHIBIT #7 & #8). He said they were using HB 533 as a vehicle because HB 531 would become an independent bill for disclosure. He said that HB 533 deals with portability and pre-existing conditions. The uniform plan has to address the individual market. HB 466 only deals with small group.

SEN. JACOBSON asked why they did not put pre-existing conditions and portability together.

CHAIRMAN BENEDICT said there were some different circumstances between the individual and the group market.

Rick Hill discussed the amendments. (EXHIBIT #8)

Motion/Vote:

JOINT SELECT COMMITTEE REPORT

Page 1 of 3  
March 17, 1995

MR. PRESIDENT:

We, your Joint Select Committee on Health Care, having had under consideration HB 446 (third reading copy -- blue), respectfully report that HB 446 be amended as follows and as so amended be concurred in.

Signed:   
Senator Steve Benedict, Chair

That such amendments read:

1. Page 2, line 27 through page 3, line 5.

Following: "(2)"

Strike: the remainder of line 27 through page 3, line 5

Insert: "A health benefit plan may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 3 years preceding the effective date of coverage of an insured person. The condition may be excluded for a maximum of 12 months."

2. Page 3, line 6.

Strike: "hospital-incurred"

Insert: "hospital expense-incurred"

3. Page 3, line 7.

Following: "policy"

Insert: ", contract,"

Following: "certificate"

Strike: ", a subscriber contract, or a contract of insurance"

Following: "by a"

Insert: "health insurer,"

4. Page 3, line 8.

Following: "corporation"

Insert: ", "

Following: "or"

Strike: "a"

Strike: "subscriber contract"

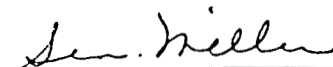
Insert: "organization"

5. Page 3, line 12.

Insert: "(5) A policy of disability income insurance may not exclude coverage for a condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 5 years

 Amd. Coord.

 Sec. of Senate

  
Senator Carrying Bill

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preceding the effective date of coverage of an insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person."

6. Page 3, line 13.  
Following: "RIDERS."  
Insert: "(1)"

7. Page 3, line 14.  
Following: "MAY"  
Strike: "EXCLUDE"  
Insert: "contain a provision that excludes"

8. Page 3, lines 15 through 17.  
Following: "RIDERS"  
Strike: the remainder of line 15 through line 17  
Insert: "for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 4 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt.

(2) An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract.

(3) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy."

9. Page 6, line 8.  
Insert: "

NEW SECTION. Section 4. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent sections

10. Page 6, line 12.  
Following: "18."  
Insert: "An insurer may not, as a result of the application of [this section], seek reimbursement for any claims previously paid. "

Page 3 of 3  
March 17, 1995

-END-

Amendments to House Bill No. 446  
Third Reading Copy

Requested by Representative Scott Orr  
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox  
March 16, 1995

1. Page 2, line 27 through page 3, line 5.

Following: "(2)"

Strike: the remainder of line 27 through page 3, line 5

Insert: "A health benefit plan may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 3 years preceding the effective date of coverage of an insured person. The condition may be excluded for a maximum of 12 months."

2. Page 3, line 6.

Strike: "hospital-incurred"

Insert: "hospital expense-incurred"

3. Page 3, line 7.

Following: "policy"

Insert: ", contract,"

Following: "certificate"

Strike: ", a subscriber contract, or a contract of insurance"

Following: "by a"

Insert: "health insurer,"

4. Page 3, line 8.

Following: "corporation"

Insert: ", "

Following: "or"

Strike: "a"

Strike: "subscriber contract"

Insert: "organization"

5. Page 3, line 12.

Insert: "(5) A policy of disability income insurance may not exclude coverage for a condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 5 years preceding the effective date of coverage of the insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person."

6. Page 3, line 14.

Following: "MAY"

Strike: "EXCLUDE"

Insert: "contain a provision that excludes"

7. Page 3, lines 15 through 17.

Following: "RIDERS"

Strike: the remainder of line 15 through line 17

Insert: "for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 4 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt."

8. Page 6, line 12.

Following: "18."

Insert: "An insurer under this provision may not, as a result of the application of this provision, seek reimbursement for any claims previously paid. An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract."

Amendments to House Bill No. 446  
Third Reading Copy

Requested by Senator Benedict  
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox  
March 16, 1995

1. Page 6, line 8.

Insert: "

NEW SECTION. Section 4. {standard} Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent sections

MINUTES

MONTANA SENATE  
54th LEGISLATURE - REGULAR SESSION

FREE CONFERENCE COMMITTEE ON HOUSE BILL 446

Call to Order: By CHAIRMAN MIKE FOSTER, on April 6, 1995, at  
7:35 a.m.

ROLL CALL

Members Present:

Sen. Mike Foster (R)  
Sen. Dorothy Eck (D)  
Sen. Ken Miller (R)  
Rep. Betty Lou Kasten (R)  
Rep. Scott J. Orr (R)  
Rep. Carley Tuss (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council  
Jennifer Gaasch, Secretary

Discussion:

SENATOR MIKE FOSTER stated the reason they were meeting was to clear up some amendments. He asked Tom Hopgood, representing the Health Insurance Association of Montana, to explain the amendments. (EXHIBIT #1)

Tom Hopgood discussed Section 1, Subsection 5, lines 17-22, on page 3 of the bill. This is dealing with policies of disability income insurance which is a type of insurance bought to cover a person's income stream in the event that a person is unable to work because of a medical condition. He stated they had intended to allow an insurance company to exclude coverage for pre-existing conditions if medical treatment were received within the five years proceeding the effective date of the policy. They actually excluded the pre-existing condition if treatment was received within the five years, but they would allow the insurer to exclude that if it was more that five years prior to the effective date, which was the opposite of what they had intended to do. He said the amendments would conform all of the pre-existing condition clauses in the statute so they track each other exactly and to allow the exclusion of pre-existing conditions if treatment was secured within five years prior to the effective date of the coverage.

SEN. FOSTER said if there were no questions, he would entertain a motion.

Motion:

REPRESENTATIVE BETTY LOU KASTEN MOVED the amendments.

Vote:

The MOTION CARRIED UNANIMOUSLY.

ADJOURNMENT

Adjournment: 7:40 a.m.

  
MIKE FOSTER, Chairman

  
JENNIFER GAASCH, Secretary

MF/jg



## FREE CONFERENCE COMMITTEE

on House Bill 446  
Report No. 1, April 6, 1995

Page 1 of 1

Mr. Speaker and Mr. President:

We, your Free Conference Committee met and considered House Bill 446 and recommend as follows:

1. Page 3, line 18.

Following: "ADVICE"

Strike: ", DIAGNOSIS, CARE,"

2. Page 3, line 19.

Following: "SERVICES"

Insert: "unless the condition occurred"

And this FREE Conference Committee report be adopted.

For the House:

Representative Orr

Chair

Representative Kasten

Representative Tuss

For the Senate:

Senator Foster

Chair

Senator Eck

Senator Miller

ADOPT

REJECT

790933CC.Hbk

DATE 4-6-95  
HB 446

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\*ALSO ADMITTED IN IDAHO, OREGON AND WASHINGTON.

March 29, 1995

Hon. Steve Benedict  
Chairman  
Joint Select Committee on Health Care Reform  
State Capitol Building  
Helena, MT 59620

Hon. Scott Orr  
Vice Chairman  
Joint Select Committee on Health Care Reform  
State Capitol Building  
Helena, MT 59620

RE: HB-446 - Pre-existing Condition Bill

Gentlemen:

In reviewing HB-446 and my letter to both of you dated March 24, 1995, I believe it would be clearer to use the following amendment in conference committee rather than the one I previously suggested:

1. Page 3, Line 18.  
Following: "ADVICE"  
Strike: ", DIAGNOSIS, CARE,"
2. Page 3, Line 19.  
Following: "SERVICES"  
Insert: "unless the condition occurred"

With these changes, the language in subsection (5) of § 33-22-110, MCA would track exactly with subsections (1) and (2). It would be clear and all ambiguity as to the look-back period for disability income insurance would be eliminated. The subsection would read:

A POLICY OF DISABILITY INCOME INSURANCE MAY NOT EXCLUDE COVERAGE FOR A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PROVIDER OF HEALTH CARE SERVICES UNLESS THE CONDITION OCCURRED WITHIN FIVE YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON . . . .

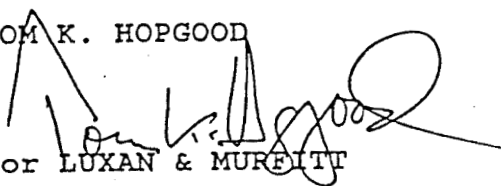
Hon. Steve Benedict  
Hon. Scott Orr  
March 29, 1995  
Page 2

I believe this is the clearest and most efficient way to accomplish our goal.

Thank you for your indulgence in this matter.

Sincerely,

TOM K. HOPGOOD



for LUXAN & MURETT

TKH/jb

cc: Mr. Robert J. Steil  
Mr. Larry Akey  
Ms. Susan Good  
Ms. Tanya Ask  
Mr. Frank Cote